NATIONAL RURAL HEALTH MISSION

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Assessment of ASHA Facilitators in Assam

February/March 2011

Regional Resource Centre for North Eastern States (RRC-NE)
Ministry of Health and Family Walfare
Government of India
Guwahati, Assam-781022

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Acknowledgement

Assessment of ASHA Facilitators in the State of Assam was conducted in February 2011 by Regional Resource Centre for North Eastern States (RRC, NE). The successful completion of the study is result of the efforts made by the study team and the support provided by Officials of District and Block PHCs and NRHM Directorate, Assam.

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Abbreviations

AF:	ASHA Facilitator
AWC:	Angan-Wadi Centre
ASHA:	Accredited Social Health Activist
ANM:	Auxiliary Nurse Midwives
AWW:	Angan-Wadi Worker
ADCM:	Assistant District Community Mobiliser
ABPM:	Assistant Block Program Manager
BPHCs:	Block Primary Health Centres
BPMU:	Block Program Management Unit
BPM:	Block Program Manager
DCM:	District Community Mobilizer
IPPI:	Intensive Pulse Polio Immunization
MO:	Medical Officer
NRHM:	National Rural Health Mission
PHC:	Primary Health Centre
PRI:	Panchayat Raj Institution
SD MHO:	Sub- Divisional Medical & Health Officer
SHG:	Self Help Group
SC:	Sub Centre
TA/ DA:	Travelling Allowances/ Dearness Allowances
TB:	Tuberculosis
VHSC:	Village Health & Sanitation Committee
VHND:	Village Health & Nutrition Day

Index

Executive Summary

Community procresses has a successful initiation in Assam since 2006. There are 28798 ASHAs in the State of Assam of which more than 90% have received training up to Module 5. To provide field level, on-job supportive supervision to ASHAs, ASHA Facilitators have been engaged. And a total of 2700 ASHA Facilitators are woriking the state. An assessment of ASHA Facilitators was conducted in Assam in Feb/March 2011 in order to understand performances of ASHA Facilitators, various constraints and challenges being faced by them as well as gaps and existing support mechanisms to address their issues.

During the study both qualitative and quantitative data were collected. A total 291 ASHA Facilitators from six districts of Assam namely; Kamrup Rural, Tinsukia, Dhubri, Dhemaji, Cachar and Nagaon were interviewed. Discussions were held with District Officials especially DCM and Block Officials especially SDMHO & BPMU staffs of BPHCs.

Findings from the study reveal that maximum ASHA Facilitators are Graduate 49% (142), followed by Higher Secondary 45% (132) and M.A. 6% (17). Maximum of them worked as teacher (25.77%) or worked in NGO (26.44%), and 24.05% were housewives before joining as ASHA Facilitator. Only 4.47% (13) of ASHA Facilitators have worked as ASHA before joining as ASHA Facilitator. More than 21% (63) of ASHA Facilitator travel more than 20 km to reach the far-most ASHA. Nearly 44% (128) of them spend more than Rs.100/- as travel and food cost during each field visit i.e. ASHA spends more than Rs. 2000/- if they make 20 days field visit per month as mentioned in the guideline. It is found that 62% (183) ASHA Facilitators are covering more than 10 (10-15) and 1.37% (4) of them are covering more than 15 ASHAs.

All the ASHA Facilitators have received training for only 3 days till now except for ASHA Facilitators of Tinsukia and Nagaon District who have received 5 days training. The need for re-training was shared by ASHA Facilitators. The meeting of VHND is found to be happening monthly in all the districts, which were studied but the meeting of the VHSC, ASHAs and ASHA Facilitators meeting does not take place regularly in all the districts. In every district, it was reported that in certain areas, these meetings are held regularly and again in the same district in few areas, these meetings are irregular. The quality of the meeting,

wherever it happens also needs much improvement as these meetings have serious lacking in terms of recording the meeting minutes and other data capturing related to programmatic achievements and areas of concern and action taken report etc. .

All ASHA Facilitators have been provided with Diary. However, the present system of record keeping at ASHA Facilitator Diary needs much improvement. It was seen almost in all the blocks of all the districts that incomplete pages in the Diary were signed by the ANMs.

As far as contributions of ASHA Facilitators are concerned, it is understood that they are supporting ASHAs mostly in maternal health, newborn & child health, and family planning. They strongly opined that their contribution is also one among the factors in reducing the maternal and infant death, increasing institutional delivery and also in increasing immunization coverage in their respective area. However, all of them wanted more training / orientation / re-training to further excel in their performances in order to address the health problems of the locality. Issues related to incentive/honorarium and TA/DA, transport and communication was among the major challenges being faced by ASHA Facilitators.

As shared by the respondents i.e. ASHA Facilitators, BPMU staffs and SDMHOs, the major areas, where more supports are sought for include; their regular training and re-orientation, a revised incentive package/honorarium & travelling allowances, effective support especially at block level with a full time staff responsible for ASHA program, strengthening their capacity on maintenance of record / Diary.

Chapter 1- Background

Introduction:

The mission document of National Rural Health Mission spells clearly the importance of community participation as part of the decentralized process of health care management and service delivery. Community participation/processes can be seen as an essential element in national health strategic plans or policies of India under NRHM.

One of the key components of the community processes under National Rural Health Mission is to provide every village in the country with a trained female community health activist – 'ASHA' or Accredited Social Health Activist. Selected from the village itself and accountable to it, the ASHA will be trained to work as an interface between the community and the public health system. ASHA is the first port of call for any health related demands of deprived sections of the population, especially women and children, who find it difficult to access health services.

The State of Assam, till date have selected 28798 ASHAs of which more than 90% have been trained up to 5th Module. The training curriculum broadly includes; introduction to health, NRHM, Maternal and new-born health, Child health and nutrition, family planning, infectious diseases like; TB, Malaria etc. and social mobilization.

The importance and the need of providing supportive supervision up to the field/village level, for effective functioning of ASHA program was realised by the State of Assam,and therefore, the support structure of ASHA program at state, district, block and sector/field level was established in Assam in February 2009 to provide the direct field level on job training/supervision of ASHAs. The State have engaged 1 (one) ASHA Facilitator for nearly / every 10 ASHAs. The ASHA Facilitators are expected to have 20 days of field visits to provide on job training/support to ASHAs and 5 days of work at the Block PHC under which they are posted. They are provided with an honorarium of Rs.500 every month and Rs. 150/- for each field visits i.e. Rs. 3000/- (150 X 20 days). Therefore, on an average they receive Rs. 3500 per month. Till date 2700 ASHA Facilitators have been engaged and are providing field level support to the ASHAs.

The need for assessment of ASHA Facilitator was felt necessary in order to understand various contributions being made by her for improving the healthcare service delivery as well the existing contraints and challenges that ASHA Facilitators are facing. The study will help in finding necessary immediate and long term measures/steps for further strengthening the program, and optimally use the existing workforce within the community.

Aim of the study:

The study aims at understanding the contribution of ASHA Facilitators as well as constraints and challenges faced/facing, and coming up with possible strategies/recommendations for improving her performance.

Objectives of the study:

The objectives of the study are to;

- Understand the various tasks performed by ASHA Facilitator;
- Find out the amount of time that she spends for her activities;
- Know the various challenges faced/facing by ASHA Facilitator;
- Undertsanding the existing support mechanisms;
- Find out the possible measures for improving the performance of ASHA Facilitator.

Chapter 2- Methodology

Study area:

For the purpose; six districts are selected from different regions of the states which includes;

1. Cachar
2. Dhemaji
3. Dhubri
4. Kamrup Rural
5. Nagaon
6. Tinsukia

The selection of the districts is done in such a way that, the study represents the whole state.

Sample and sampling:

Systematic random and proportionate sampling method was used to select/sample ASHA Facilitators for interview/study. Of the 2700 ASHA Facilitators in the State, 859 are from the six Districts selected for the study. One third (i.e. 33% or more) of the 859 ASHA Facilitators from these six sample districts are selected for the study in order to have sample size more than 10% of the total ASHA Facilitator in the State. Therefore, it was decided to take interview of 283 ASHA Facilitators. However, during the course of data collection another 8 additional ASHA Facilitators (who came forward voluntarily) were also interviewed, which has made the total sample size to 291 ASHA Facilitators.

Table: District wise distributionof sample (AF)

SN	District	Actual No. of AF	Sample AF selected (33%)
1	Dhubri	148	49
2	Cachar	160	53
3	Dhemaji	71	23
4	Kamrup®	158	52
5	Tinsukia	124	41
6	Nagaon	198	65
TOTAL		**859**	**283 + 8 additional = 291**

Sampling interval = Total AF Sample size = 859/283 = 3

Selection of sample (ASHA Facilitator) from each district for the interview:

For this purpose, listing of each BPHC in each of the district was done. Thereafter, the Block/BPHC-wise listing of ASHA Facilitator was done in alphabatic order (with their initial name) and accordingly the sample (AF) was selected with the given sampling interval (i.e.3). In such way 33% i.e. one third of the ASHA Facilitator of each block were slected leading the selection of 33% ASHA Facilitators of each district (sampled districts).

The sample selection (AF) was done with a sampling interval of 3. i.e. if the 1st AF from the list is selected as the first sample, the 4th AF in the list was the second sample, and so on.

Tools of data collection:

Structured interview schedule was used to collect quantitative data from the ASHA Facilitator through face to face interview. Prior to the data collection, this schedule was field tested among the ASHA Facilitators in Azara BPHC area of Kamrup District. Based on the experiences and feedback received during field testing, the final interview schedule was prepared.

In addition, the team also interacted and discussed with the Staff of BPMU and BPHC such as SDMHO, BPM, ABPM, ANM, Staff nurse etc. and collected qualitative information related various contributions being made by ASHA Facilitator, challenges and constraints that she is facing. They were also asked to suggest possible measures/strategies and recommendations for making ASHA Facilitator more effective.

Chapter 3- Findings of the Study

Background of the ASHA Facilitators:

All the ASHA Facilitators (291), who were interviewed, are married except a few. Most of the ASHA Facilitators are in the age group of 30-39. As far as their educational qualification is concerned, as provided in the table below (Table No. 1) maximum of them i.e. 142 (49%) are graduate, followed by 132 (45%) higher secondary and 17 (6%) are Master Degree. Most of the ASHA Facilitators had work experiences before joining. Around 27% (83) have worked in NGO, 26% (75) as teacher and 24% (70) did not have any work experience (housewife). Only 4.45% (13) of them were ASHA before becoming ASHA Facilitator. Table No. 1 and 2 provides details of qualifications and work history of ASHA Facilitators interviewed in each of the district.

Table 1. Qualification of ASHA Facilitators

District	HS		Graduate		MA		Total
	No.	%	No.	%	No.	%	%
Cachar	29	52.73	22	40	4	7.27	100
Dhemaji	7	70.83	17	29.17	0	0	100
Dhubri	13	65.38	34	25	5	9.62	100
Kamrup	27	41.18	21	52.94	3	5.88	100
Nagaon	29	50	34	42.65	5	7.35	100
Tinsukia	27	34.15	14	65.85	0	0	100
Total/Average	132	45%	142	49%	17	6%	100

ASHA Coverage by ASHA Facilitators:

The data analysis shows that around 62% (184) ASHA Facilitators are facilitating more than 10 ASHAs each, while nearly 36% (107) are facilitating less than 10 (8-9) ASHAs, and 1.37% (4) of them are facilitating more than 15 ASHAs. Table No. 3 provides district wise information related to number of ASHA and VHSC covers by each ASHA Facilitator.

Table No. 3 - Number of ASHA supervise & VHSC coverage

District	Less than 10		10 to 14		15 & above		Total	
	No.	%	No	%	No	%	No	%
Cachar	21	38.18	34	61.82	0	0.00	55	100.00
Dhemaji	4	16.67	20	83.33	0	0.00	24	100.00
Dhubri	20	38.46	32	61.54	0	0.00	52	100.00
Kamrup	9	17.65	42	82.35	0	0.00	51	100.00
Nagaon	41	60.29	25	36.76	2	2.94	68	100.00
Tinsukia	12	29.27	27	65.85	2	4.88	41	100.00
Total	107	36.77	180	61.86	4	1.37	291	100.00

It also reveals that 85.57% (249) ASHA Facilitators make 20 days field visit in a month, 11.68% (34) of them make 15-19 days field visit in a month and rest nearly 3% (8) of them make less than 15 days field visit in a month. Table no. 4 provides district wise information on number of field visits conducted by ASHA Facilitators in a month. During each field visit, most of them interact with 2-3 ASHAs and spend nearly 2-3 hours with each ASHA.

Table No. 4- Number of field visit days in a month

District	Less than 15		15-19		20 & above		Total	
	No	%	No	%	No	%	No	%
Cachar	3	5.45	10	18.18	42	76.36	55	100.00
Dhemaji		0.00		0.00	24	100.00	24	100.00
Dhubri	3	5.77	18	34.62	31	59.62	52	100.00
Kamrup	2	3.92	1	1.96	48	94.12	51	100.00
Nagaon		0.00	5	7.35	63	92.65	68	100.00
Tinsukia		0.00		0.00	41	100.00	41	100.00
Total	8	2.75	34	11.68	249	85.57	291	100.00

Distance coverage and Mode of travels

As far as the distance covered by ASHA Facilitators is concerned, for reaching the nearest ASHA, ASHA Facilitators travel less than 1 km and for that they walk or use rickshaw as mode of travel. However, more than 24% (71) ASHA Facilitators are travelling 5-9 kms, more than 23% (68) ASHA Facilitators travel more than 10-14 kms and nearly 22% (63) travel more than 20 kms to reach to the far most ASHA. 19% ASHA Facilitators travel more than 20 kms or more. More than 80% of them go to those areas by bus / rickshaw / auto / scooter / bi-cycle and also many a times they need to walk some part of the total distance. Table No. 5 provides district wise information on distance travel by ASHA Facilitator to reach the far-most ASHA in her area.

In addition to this many of the ASHA Facilitators have to travel more than 10 km only to reach their posting site from resident village. It was informed that from those places right candidate for the position of ASHA Facilitator was not found and as a result of which ASHA Facilitator from outside was assigned with the responsibilities of facilitating ASHAs of the area.

Table No. 5- Far-most ASHA from posting site of ASHA Facilitator (km)												
District	Less than 5		5 to 9 km		10 to 14 km		15 to 19 km		20 km & above		Total	
	No	%	No	%	No	%	No	%	No	%	No	%
Cachar	6	10.91	12	21.82	20	36.36	7	12.73	10	18.18	55	100.00
Dhemaji	1	4.17	8	33.33	3	12.50	6	25.00	6	25.00	24	100.00
Dhubri	9	17.31	17	32.69	9	17.31	10	19.23	7	13.46	52	100.00
Kamrup	4	7.84	9	17.65	14	27.45	14	27.45	10	19.61	51	100.00
Nagaon	12	17.65	16	23.53	10	14.71	11	16.18	19	27.94	68	100.00
Tinsukia	1	2.44	9	21.95	12	29.27	8	19.51	11	26.83	41	100.00
Total	33	11.34	71	24.40	68	23.37	56	19.24	63	21.65	291	100.00

Meeting and related information:

Information related to various meeting such as meeting of ASHA, VHSC, VHND and ASHA Facilitator were collected. Discussions revealed the following;

- Monthly meeting of ASHAs on 1st Saturday happens at Sub Centre, which is attended by all the ASHAs under the ASHA Facilitator. ANM and AWW also sometime attend the meeting, as reported. During the meeting, performance of each ASHA is discussed and recorded at ASHA Facilitator's diary and various issues are discussed, where intervention of ASHA Facilitator is needed. It is found that for most of the areas, six such meetings have been conducted in last six months, which means the meeting is happening regularly. *(Please refer to table no.-6)*

- The response regarding regularity of VHSC meeting was mixed. In certain Block PHCs in all the districts, it was reported that monthly VHSC meeting is conducted but in certain Block PHCs in all the districts like South Salmara (Dhubri), Harinagar (Cachar), Hajo, Nagarbera and Upparhali (Kamrup Rural), and Dagaon, Singimari, Lanka and Samaguri block (Nagaon) the meeting is highly irregular. While citing the reasons for irregular holding of VHSC meeting, ASHA Facilitators told that in many areas though ASHAs want to have meeting but the President of the VHSC (PRI member) wants money from VHSC fund to call the meeting. Due to such behavior of PRI member, many ASHAs are de-motivated to call VHSC meeting. There is no fixed

date / day for holding the meeting but wherever it is held regularly, there the next date of meeting is decided during the time of the meeting itself. The meeting is attended by most of the VHSC members; ASHA, AWW, Teacher, SHG member, PRI member and also ASHA Facilitator. However, it is revealed that ANM rarely attend the meeting. Various issues related to health and sanitation is also discussed during the meeting. *(Please refer to table no.-6)*

- For most of the Block PHCs of the districts, it is found that the monthly meeting of ASHA Facilitators at Block PHC is held regularly except few BPHCs like Chapar (Dhubri), Harinagar, Udharbond (Cachar). However, the ASHA Facilitators meeting in most places is clubbed with the monthly performance review meeting of BPHC staffs and staffs of various PHC/Mini-PHC/SC within the block. This meeting is attended by SDMHO, BPM, ANMs and ASHA Facilitators. In the meeting, ASHA Facilitator wise performances are discussed and suggestions are given. As for almost all the BPHCs, the meeting minute is not properly recorded so not much can be commented on the quality of inputs, which are given during the meeting. For almost all the BPHCs, the detail meeting minute is not recorded, only signature of the person, who attended the meeting are seen. *(Please refer to table no.-6)*

Table No. 6.- Meeting related information

District	ASHA Facilitator Meeting at BPHC				ASHA Meeting				VHND				VHSC			
	Regular		Iregular		Regular		Irregular		Regular		Irregular		Regular		Irregular	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Cachar	43	78.2	12	31.8	55	100	0	0	55	100	0	0	50	91	5	9
Dhemaji	24	100	0	0	24	100	0	0	24	100	0	0	21	87.5	3	12.5
Dhurbi	44	84.6	8	15.4	52	100	0	0	52	100	0	0	44	84.6	8	15.4
Kamrup R	51	100	0	0	51	100	0	0	51	100	0	0	37	72.5	14	17.5
Nagaon	68	100	0	0	68	100	0	0	68	100	0	0	45	66.2	23	33.8
Tinsukia	41	100	0	0	41	100	0	0	41	100	0	0	40	97.5	1	2.5
Total	**271**	**93.1**	**20**	**16.9**	**291**	**100**	**0**	**0**	**291**	**100**		**0**	**237**	**81.4**	**54**	**18.6**

Considering the records, what could be seen during study that conveners of the different meeting at different level like ASHA Facilitator at SC level, SDMHO & BPM at BPHC level are not very clear about what are the core non-negotiable activities are to be carried out in the

meeting and as a result of which these meeting hardly address the core issues like analyzing the record captured at different level and suggesting steps of improvement, if data quality is found poor. Another major point, which is found to be missed out is prioritizing the follow up activities to be done based on the analysis of the data. Presently in the meeting, field level data is captured (without much analysis) and programmatic information is given, if any, like informing dates of IPPI. So, it is very urgent that role clarity and activities to be performed during review meeting is made clear to all the stakeholders. *This issues was common in all across the blocks/districts.*

It is appreciable that in all the districts and areas of the BPHCs, monthly VHND is organized either at AWC or at concerned SC, and is happening regularly in all the places *(Please refer table -6).* For most of the BPHCs, it is also shared that VHND is clubbed with immunization day and wherever it is separately held, there it is held on either Friday or Saturday. The places where VHND is not clubbed with immunization day, it is reported that hardly ANM attend such VHND.

Regarding financial support in organizing the VHND, 82.82% (241) of the ASHA Facilitators told that Rs.100 per VHND is used, which is given to ASHA as cost of refreshment & incentive for mobilizing community. Further, 11% (32) of ASHA Facilitators told that VHSC releases Rs.200 (Rs.100 for refreshment & Rs.100 as ASHA incentive) for organizing VHND. Table No. 7 shows the district wise details of amount of money released by VHSC for organizing VHND.

Table No. 7- Total amount for Meeting

District	Rs.50		Rs.100		Rs.150		Rs.200		Grand Total	
	No	%	No	%	No	%	No	%	No	%
Cachar	1	1.82	35	63.64	2	3.64	17	30.91	55	100.00
Dhemaji	0	0.00	24	100.00	0	0.00	0	0.00	24	100.00
Dhubri	1	1.92	51	98.08	0	0.00	0	0.00	52	100.00
Kamrup	7	13.73	25	49.02	7	13.73	12	23.53	51	100.00
Nagaon	0	0.00	68	100.00	0	0.00	0	0.00	68	100.00
Tinsukia	0	0.00	38	92.68	0	0.00	3	7.32	41	100.00
Total	9	3.09	241	82.82	9	3.09	32	11.00	291	100.00

Training and training need of ASHA Facilitator

Training is considered to be one among the major initiative for enhancing the knowledge level and thus ultimately increasing the performances of ASHA Facilitators. However, study report regarding the duration of training given to the ASHA Facilitators is not encouraging. All the ASHA Facilitators have been trained only for 03 (three) days (*induction training*) except Tinsukia & Nagaon District, where the ASHA Facilitators are trained for 5 days (additional 1 day each on malaria and anemia). Table no. 8 provides district wise information on status of training.

It was also informed that in those 3 days *induction training*, they were trained on entire gamut of NRHM in general and community processes in particular. Major topics, which were covered, include; NRHM and its genesis, role of ASHA and ASHA Facilitator, VHSC, VHND, Maternal Health, Newborn and Child Health, different National Disease Control Program like Malaria, Tuberculosis, Blindness Control, Leprosy etc. While commenting on the training inputs and the duration of the training ASHA Facilitators commented that they found the training very heavy as duration was too short as compared to inputs. Few of the ASHA Facilitators even suggested training on different life skills like effective communication skill, coordination skill, negotiation skill, leadership skills etc. The need for re-training and orientation was shared by all the ASHA Facilitators. To satisfy the training on life skills, ASHA Facilitators can be trained in ASHA Module V.

ASHA Facilitators also attended few meetings either at District (like introductory meeting at District in presence of the concerned District Deputy Commissioner) or at BPHCs (like attending specific planning meeting on IPPI), but it is shared that they did not get much inputs in those trainings related to their job profile.

Table no. 8- Training information/status

District	Training					
	3 days training		1 day Training on Malaria		1 day Training on Anaemia	
	No.	%	No.	%	No.	%
Cachar	55	100%	0	0	0	0
Dhemaji	24	100%	0	0	0	0
Dhurbi	52	100%	0	0	0	0
Kamrup rural	51	100%	0	0	0	0
Nagaon	68	100%	68	100%	68	100%
Tinsukia	41	100%	41	100%	41	100%
Total	**291**	**100%**	**109**	**37.45%**	**109**	**37.45%**

Honorarium and incentive of ASHA Facilitator and expenditure incurred:

The study reflects that all the ASHA Facilitators received a total amount of Rs. 3500 (Rs.500 Honorarium + Rs.3000 TA/DA) every month. For most of them, they could not tell the breakup of the TA & DA amount.

Another interesting fact, which was shared by few of the ASHA Facilitators that in remote and very difficult areas (hilly terrain and char / riverine areas), it is very difficult to go for 20 days field visit followed by few days visit at the BPHC. In certain situation, they are compelled to reflect 20 days field visits in their record so as to satisfy the norms of field visit and thus to get the entire honorarium + incentive per month.

During study, it was observed that in difficult hilly terrain and in char / riverine areas (like khasia punjis under Bikrampre BPHC, Harinagar BPHC in Cachar District, Jonai BPHC, Sisibargaon, Gogamukh BPHC in Dhemaji District and char areas of different BPHCs under Dhubri District and most areas in Tinsukia District, it is really difficult to make 20 days field visits + few days visits at the BPHC. The frequent field visit is also restricted for poor allocation of areas to the ASHA Facilitators. It is reported in Chapor (Dhubri), Buragohainthan, Jakhalabandha, Barapujia (Nagaon), Jonai (Dhemaji) Ketetong, Hapajan (Tinsukia), and in Blocks of Kamrup Rural, that for most of the ASHA Facilitators, the allocated area is at far distance from their home, which is restricting their field movement, whereas ASHA Facilitators from other area is coming and working in her area. So, re-allocation of area among ASHA Facilitators may be the most effective answer to deal with the situation, which will also increase the total field visit days by each ASHA Facilitator.

As far as average monthly expenditure during field visit (travel fare/food etc.) is concerned, 44% (123) of them spend more than Rs.2000, while 67 (23%) spend Rs. 3000 per more, and only 4.81% (14) of them spend less than Rs.1000 during field visit.

Table No. 9 shows district wise information on monthly expenditure incurred by ASHA Facilitators during field visit.

Table No. 9- Total amount for field visit(Rs.)												
District	Less than 1000		1000 to 1499		1500 to 1999		2000 to 2999		3000& above		Total	
	No	%	No	%	No	%	No	%	No	%	No	%
Cachar	3	5.45%	7	12.73%	9	16.36%	16	29.09%	20	36.36%	55	100.00%
Dhemaji	0	0.00%	0	0.00%		0.00%	21	87.50%	3	12.50%	24	100.00%
Dhubri	2	3.85%	10	19.23%	6	11.54%	25	48.08%	9	17.31%	52	100.00%
Kamrup	3	5.88%	9	17.65%	13	25.49%	20	39.22%	6	11.76%	51	100.00%
Nagaon	6	8.82%	8	11.76%	12	17.65%	35	51.47%	7	10.29%	68	100.00%
Tinsukia	0	0.00%	4	9.76%	4	9.76%	11	26.83%	22	53.66%	41	100.00%
Total	14	4.81%	38	13.06%	44	15.12%	128	43.99%	67	23.02%	291	100.00%

Overall contributions of ASHA Facilitators and major area of improvement in health care delivery system:

It is found that, majority of the ASHA Facilitators are contributing in the area of social mobilization, maternal and newborn/child health and family planning. However, their contributions in national disease control program like malaria, tuberculosis is minimal. Table No.10 shows District wise information on area of contributions being made by ASHA Facilitator.

It is opined by ASHA Facilitators that improvements in the health status have been observed because of effective social mobilization and for working closely with ASHAs. More than 85% ASHA Facilitators informed that institutional delivery has improved, 64% of them shared that there is sharp increase in number of people adopting family planning methods (temporary & permanent), more than 56% expressed that death of infant & children has reduced, 47% opined that there is decline in maternal deaths too. Table No. 11 reflects the district wise information on different areas of improvements in health status of community.

Table 10. Major areas of contribution by ASHA Facilitator										
	Maternal health		Child/Newborn health		Family Planning		Social Mobilization		TB/Malaria	
District	No.	%	No.	%	No.	%	No.	%	No.	%
Cachar	19	34.55%	23	41.82%	27	49.09%	20	36.36%	17	30.91%
Dhemaji	23	95.83%	23	95.83%	19	79.17%	15	62.50%		0.00%
Dhubri	37	71.15%	39	75.00%	47	90.38%	12	23.08%	11	21.15%
Kamrup	37	72.55%	32	62.75%	50	98.04%	5	9.80%	12	23.53%
Nagaon	40	58.82%	41	60.29%	38	55.88%	45	66.18%	8	11.76%
Tinsukia	27	65.85%	22	53.66%	25	60.98%	14	34.15%	8	19.51%
Total	183	62.89%	180	61.86%	206	70.79%	111	38.14%	56	19.24%

Table 11. Areas of improvement in health status of community										
	Increase Inst. Delivery		Child/Newborn health		Family Planning		Maternal Health		Increase Imunization	
District	No.	%	No.	%	No.	%	No.	%	No.	%
Cachar	44	80.00%	21	38.18%	40	72.73%	29	52.73%	26	47.27%
Dhemaji	19	79.17%	22	91.67%	18	75.00%	16	66.67%	1	4.17%
Dhubri	41	78.85%	30	57.69%	34	65.38%	24	46.15%	4	7.69%
Kamrup	43	84.31%	21	41.18%	27	52.94%	19	37.25%	10	19.61%
Nagaon	62	91.18%	46	67.65%	37	54.41%	40	58.82%	1	1.47%
Tinsukia	40	97.56%	25	60.98%	32	78.05%	10	24.39%	0	0.00%
Total	249	85.57%	165	56.70%	188	64.60%	138	47.42%	42	14.43%

Major Challenges faced by ASHAs

While speaking on major challenges being faced by ASHAs, it was told by more than 68% ASHA Facilitators that untimely payment of ASHA incentive is the biggest challenge, which has been de-motivating ASHAs. Nearly 54% of the ASHA Facilitators shared that transport/communication related problem is another major challenge, while 28% talked about lack of knowledge of ASHAs as major challenge and another 18% shared that dealing with PRI is a major challenge, which is faced by ASHAs. In order to help ASHAs in facing those challenges, it was informed by 86% of ASHA Facilitators that they motivate ASHAs, 48% told that they make home visits with ASHAs, 18.56% opined that they conduct regular meeting with ASHAs and 13% expressed that they prefer to give on-job training to ASHAs to make them able to address their challenges. Table No. 12 & 13 provides district wise

information on major challenges faced by ASHAs and nature of support being provided by ASHA Facilitators to ASHAs for dealing with these challenges.

Table No. 12- Support provided by ASHA Facilitator to ASHAs for dealing with challenges

	Motivating ASHA		Home visit with ASHA		Meeting PRI		Training to ASHA		Others	
District	No.	%	No.	%	No.	%	No.	%	No.	%
Cachar	34	61.82	34	61.82	17	30.91	3	5.45	25	45.45
Dhemaji	24	100.00	10	41.67	2	8.33	3	12.50	0	0.00
Dhubri	46	88.46	13	25.00	10	19.23	3	5.77	8	15.38
Kamrup	44	86.27	31	60.78	18	35.29	9	17.65	3	5.88
Nagaon	65	95.59	39	57.35	2	2.94%	15	22.06	6	8.82
Tinsukia	38	92.68	13	31.71	5	12.20	6	14.63	2	4.88
Total	251	86.25	140	48.11	54	18.56	39	13.40	44	15.12

Table no. 13- Major challenges faced by ASHAs

	Incentive related		Transport/ Communication		Knowledge/Training		Dealing PRI	
District	No.	%	NO.	%	No.	%	No.	%
Cachar	23	41.82	27	49.09	15	27.27	17	30.90
Dhemaji	22	91.67	18	75.00	5	20.83	2	0.80
Dhubri	27	51.92	26	50.00	16	30.77	10	19.20
Kamrup	43	84.31	23	45.10	19	37.25	18	35.30
Nagaon	63	92.65	29	42.65	16	23.53	2	0.30
Tinsukia	20	48.78	34	82.93	11	26.83	5	12.19
Total	198	68.04	157	53.95	82	28.18	54	18.55

Major challenges of ASHA Facilitators and Mechanism to address:-

Regarding challenges, which are being faced by the ASHA Facilitators, 74% informed that with the meager amount of monthly honorarium (Rs. 500) and incentive (Rs. 3000), they find it very difficult to make regular field visit and also attending the BPHC and most importantly to save little amount out of their income. In addition to this challenge, 54% expressed out that they find transport and communication related difficulties, 33.33% told about their limited knowledge also puts them into difficulty in dealing field level issues, 7.90% shared that dealing with PRI is a major challenge, which they face every now and then. The Table No 14 shows district wise information on challenges being faced by ASHA Facilitators. While speaking about the means of addressing those challenges, ASHA Facilitators informed

that they are managing the problem somehow, no concrete set strategies are used but for limited knowledge, they take help from BPMU staffs, ANMs and also read books.

Table no. 14- Major challenges faced by ASHA Facilitators

	Incentive related		Transport/ Communication		Knowledge/ Training		Dealing PRI		Others	
District	No.	%	No.	%	No.	%	No.	%	No.	%
Cachar	20	36.36	27	49	19	34.55	17	30.91	16	29.09
Dhemaji	23	95.83	18	75	8	33.33	0	0.00	1	4.17
Dhubri	41	78.85	26	50	12	23.08	0	0.00	18	34.62
Kamrup	37	72.55	23	45	20	39.22	6	11.76	6	11.76
Nagaon	60	88.24	29	43	11	16.18	0	0.00	16	23.53
Tinsukia	35	85.37	34	83	27	65.85	0	0.00	0	0.00
Total	216	74.23	157	54	97	33.33	23	7.90	57	19.59

With the introduction of ASHA Facilitators in ASHA Program, ASHAs have found someone with whom they can share their problems and concerns on regular basis. Introduction of ASHA Facilitators have greatly helped the ASHA Program in keeping close communication with ASHAs, passing information to ASHAs within very short span of time, to know their field level issues and concern, in getting field level data from ASHAs etc. Quality of record capturing by ASHAs has improved as the ASHA Facilitators do cross check the data captured by ASHAs.

Some of the major improvements, which have come after introduction of ASHA Facilitators, include - increased frequency of holding of VHND and its quality, frequency of holding VHSC meeting and its quality leading to better utilization of untied and maintenance fund, timely reporting of maternal & infant deaths by ASHAs.

The study reveals that in all the districts ASHA Facilitators have been working for more than one and half years except for Kamrup Rural where they have been in place for last 6-8 months. Generally for all the districts, ASHA Facilitators are trained for 3 (three) days except for Tinsukia and Nagaon districts, where ASHA Facilitators have also been given 1 (one) day training each on Anemia, Malaria etc. For other districts too, ASHA Facilitators have been oriented on polio program during IPPI, breast feeding before breast feeding week etc. One notable point, which was observed in Tinsukia District, is that the BPMU staffs under the leadership of the SDMHO are very serious to support ASHA Facilitators so that they can effectively perform. The performance of ASHA Facilitators of Dhemaji District also needs to be mentioned because of Project PALNA under which the district initiated a common field visit form for all ASHA Facilitators which demands 20 days compulsory field visit per month. In Borkhola BPHC of Cachar District, the SDMHO is found to be in regular interaction with ASHA Facilitators and has been guiding them.

Geographical coverage and cost incurred:

It is revealed that 64.26% (187) ASHA Facilitators travel more than 10 km to reach the farmost ASHAs. The study further reflects that most of the ASHA Facilitators need to travel more than 20 km onlyto reach their posting sites. On an average, it is reported that monthly

they spend around Rs. 2000 as travel cost and food for making 20 field visits. To decrease the level of expenditure sometime they make less number of field visits but 20 days field visit is reported.

Training and Training need

The findings of the study reveals that more than 90% of the ASHA Facilitators have received training for only 3 days except for ASHA Facilitators of Tinsukia & Nagaon District, who have received training for 5 days. In 3 (three) days training, they were trained on NRHM and its genesis, role of ASHA and ASHA Facilitator, VHSC, VHND, Maternal health, Newborn and Child Health, different National Disease Control Program like Malaria, Tuberculosis, Blindness Control, Leprosy etc. Since, duration of the training was very less so ASHA Facilitators expressed that there is need for more training / re-orientation.

Monthly review meeting of ASHA Facilitators:

It was observed that in few BPHCs of Tinsukia (Hapajan), Nagaon (Jaklabandha, Lanka, Kotiathali, Buragohainthan), Cachar (Borkhola, Jallalpore) and Dhemaji (Dhemaji) separate meeting is held with ASHA Facilitators under the leadership of the SDMHO, the BMPU staffs. In the meeting, ASHA Facilitators share their performances and concerns and necessary suggestions are taken for improvement. Though such step of the BPHC is appreciable but it was seen that many of them are not very sure about the activities to be performed to make the meeting highly result-oriented. Except for the above mentioned BPHCs, the ASHA Facilitators meeting is always clubbed with the monthly review meeting of health staffs at BPHC level.

Other meeting and role of ASHA Facilitator:

It is appreciable that the VHND is held regularly in all the BPHC areas of all the districts but the frequency of organizing other meeting is an area of concern. The meeting of ASHAs at SC level (preferably on 1st Saturday of the month) is also held regularly except in very few areas under South Salmara BPHC of Dhubri district. The monthly meeting of the ASHA Facilitators (either separate or single meeting at BPHC) at the BPHC level also held in the BPHCs of all the districts except few BPHCs spread over in Dhubri, Cachar, Nagaon, where the meeting is not regular. Same picture is seen regarding the frequency of the VHSC meeting. The VHSC meeting is also held in all the districts but the frequency is not very regular. Moreover, record keeping for most of these meetings in all the districts is not

encouraging, so not much conclusion can be drawn after seeing the meeting register. For most of the BPHC's in all the districts, for many of the meetings, only signature is kept for the persons, who attended the meeting.

Record keeping

Almost all ASHA Facilitators have been provided with Diary to capture their field level performances. However, the present system of record keeping of ASHA Facilitator (which is based on their diary) needs to be improved as many of them do not maintain proper records in their diary. The analysis of the data captured in the diary is almost missing. It was further informed that the Staff of ASHA Resource Centre at district i.e. DCM, ADCM and also ASHA Facilitators have not been trained on the diary, so whatever the ASHA Facilitators could understand by reading, they are filling the diary accordingly. In all the BPHC of all the districts in few diaries it was found that the blank as well as incomplete pages of diary were signed by ANM.

Moreover, it is seen during study that even the records, which are submitted by ASHA Facilitators at the BPHC are also kept in a very disorder way i.e. putting all the reports in one file, wherefrom finding out a particular report becomes very difficult. It is appreciable that in Raniganj BPHC, the records of the ASHA Facilitators are kept separately but these reports are hardly analyzed to guide in a better way to ASHA Facilitators.

Contributions of ASHA Facilitators:

As far as contributions of ASHA Facilitator are concerned, it is mostly on maternal health, newborn health, child health and family planning. Most of the ASHA Facilitators have shared motivating ASHAs as their major strategies of dealing with problems faced by ASHAs, followed by visiting beneficiaries with ASHAs.

Major constraints and challenges faced by ASHA and ASHA Facilitators

Issues related to untimely payment of ASHA incentive was shared as one of the biggest challenge for ASHAs. This many a times makes them less effective in motivating ASHAs. Other challenges faced by ASHAs include those challenges related to transport and communication. In addition to this, the need to increase the amount of incentive under various programs was also expressed by ASHA Facilitators.

The issues of dealing with PRI members and their corrupt nature were alsoshared by ASHA Facilitators especially in Kamrup, Nagaon and Dhubri. ASHA Facilitators also shared that the limited knowledge level, poor transport & communication are among the major challenges. As mentioned earlier, increased incentive package coupled with re-orientation training may enhance their performances, they opined.

Support mechanism

The State of Assam has support srtucture for ASHA program at State, District (ASHA Resource Centre) and Block level through BPHC/BPMU.

State/District ASHA Resource Centre has been outsourced to DonBocso Institute (DBI), Guwahati. The Resource Centre at State level consist of six staff (One State Program Manager, One State Community Mobilizer, Three Coordinators and One Consultant). At District level DBI has two staff to provide support to the program (One District Community Mobilizer and One Assistant District Community Moibilizer). State ASHA Resource Centre organizes two days bi-monthly review meeting for DCM and ADCM at DBI (Guwahati). During the meeting performance of each district is reviewed, and inputs are provided by the state ARC. This is also taken as an opportunity for sharing the experiences of each other. This is followed by motivational session. In addition to the review meeting, staff of State ARC visits to the districts regularly, especially during the time of training and other activities such as VHND, review meeting of ASHA Facilitators at block level etc. Information through the ASHA Facilitator diary which is developed by the ARC (DBI) is collected and collated by the DCM/ADM at district level and is shared with the State ARC on monthly basis. This process has begun around 6 months back (Sept/Oct 2010). However, there is lack of analysis as well usage of the data for field level program implementation/strengthening. The analysis is limited to only whether all the columns/rows in the diary are filled or not.

There is a daily reporting system through mobile phone (SMS) on activties of DCM & ADCM to the State ARC. However, similar to above situation, effective usage of this report/data send on SMS on daily basis was not recognized during the time of data collection.

This system could broadly be seen only as a mechanism of tracking the daily activties of ADCM and DCM. The same feeling was also shared by the DCMs during the time of data collection.

Direct support to the ASHA Facilitator is provided through BPHC/BPMU as well as by District Community and Assistant District Community Mobilizer. At least once in every week, ASHA Facilitator attends the BPHC. Once in every month, there is review meeting of ASHA Facilitator at BPHC which is attended by BPMU Staff, BPHC staff specially SDMHO, Nurse and doctors.

As far as support of ASHA Resource Centre (especially DCM and ADCM) is concerned, the support provided to the ASHA Facilitator is limited to attending the review meeting of the ASHA Facilitators and orientation.

Expired Drugs

Unfilled Records / Diary

Unfilled Records / Diary

Drug lying on the floor

Chapter 5- Reccommendations

Geographical coverage

More than 64% ASHA Facilitators have to travel more than 10 km during their field visit to reach far most ASHAs, and in addition most of them have to travel 20 km to reach their posting site. Therefore, the amount of incentive and TA & DA needs to be revised and immediate relocation for many of the ASHA Facilitators is required. For this purpose the ASHA Resource Centre especially DCM/ADCM may take the initiative with BPMU/BPHC for mapping the ASHA Facilitator's area and accordingly identified ASHA Facilitators need to be relocated.

Training

ASHA Facilitators may be trained on Module-5, 6 & 7, which covers the topics covered in ASHA Module 1-4. Training of ASHA Facilitators on Module 6 & 7 will give them detail understanding about different. Thematic areas (Maternal health, Newborn and Child Health, different National Disease Control Program like Malaria, Tuberculosis, Blindness Control, Leprosy etc) and Module 5 will cover different life skills such as coordination skills, negotiation skills, leadership skills, decision making skill, communication skill etc. Monthly review meeting may also be taken as an opportunity for their re-orientation (if it is organized separately), where ARC staff (DCM/ADCM) needs to play an active role.

Monthly Revierw meeting of ASHA Facilittaor

The monthly review meeting of ASHA Facilitators needs to be organized separately instead of mixing it with the monthly BPHC level meeting of all health staffs. This should be seen as an effective platform for providing re-orientation to them on selected health topics/issues/ASHA Facilitator's Diary. Moreover, DCM/ ADCM should compulsorily attend the monthly review meeting of ASHA Facilitators in each of the block. In the meeting, ASHA Facilitators should also be oriented on analyzing the data captured and should draw the activity plan for the next month.

Other meeting and role of ASHA Facilitator

With an aim to improve the meeting quality, it is suggested that the SDMHO, BPM, ASHA Facilitators needs to be re-oriented on their expected role and responsibilities in providing

supportive supervision to ASHAs and in VHSC, ASHA Meeting. State ASHA Resource Centre may take a lead role in this initiative.

Record Keeping

There is need for orienting ASHA Facilitators on their diary. Prior to the orientation of ASHA Facilitators, the DPMU (ASHA Resource Centre, especially DCM, ADCM) and BPMU (BPM, BAM) need to be oriented on filling up diary, strategies of analysis and using the analysis for planning. It is strongly recommended that separate guard file should be maintained for each ASHA Facilitator and analysis of the records should be done. Keeping reports separately itself becomes a monitoring indicator for the DPMU & BPMU to assess the performances of the ASHA Facilitators.

Contributions of AF

ASHA Facilitators need to be informed that they need to make home visits with ASHAs to those houses where ASHAs are not being accepted, and to some of the selected houses where ASHAs have provided some services. They need not make home visit with ASHAs just like that (without analysis). They may be sensitized on this issue during their monhtly revie wmeeting. A common field visit checklist for all the districts should be developed which may be used by ASHA Facilitators for their 20 days field visit. ASHA Resource centre (State and District) may take this initiative on priority.

Challaneges and constraints of ASHA Facilitator

In order to address the challenges and constraints being faced by ASHA Facilittaors, as mentioned earlier, increased incentive package and TA/DA for field visit coupled with re-orientation training may enhance their performances.

The monthly honorarium for ASHA Facilitator may be considered for enhancement in view of their extensive field work and proposed extra activities for which they may be involved at block PHC level and Sub Centre level program implementation.

Likely Greater Roles of ASHA Facilittaiors

It is revealed from the study that, many a times ASHA Facilitators are involved in various activities which hampers their actual assigned tasks. However, it is felt that ASHA

Facilitators can be engaged into more meaningful tasks (such as a trainer for ASHA and community level actions like development of Village Health Plan) provided they are given enough opportunities for building their capacities, and thereafter, given regular/enough handholding support from the State/District/Block.

Though at present, ASHA Facilitators are collecting and maintaining data/information, there is need for trendous improvement. Moreover, there is no system of reporting qualitative information such as success stories or contributions/achievements, field level challenges and contraints etc. They may be effectively engaged in documentation of not only quantitative but also qualitative information, which will help the support structure (Block/District/State level) to understand various existing field level situations for further strengthening the program by prioritising their tasks.

ASHA Facilitator could also play an active role in supporting/guiding the ASHAs for collecting field level data/information on Mother and Child Tracking System, Monthly Maternal and Infant Death Status format (M1 and M2), ASHA Diary etc., and authenticating the same.

Support mechanism

Considering the size of districts in a state like Assam, there is need for effective involvement of staff of BPMU and BPHC in supportive supervision of ASHA Facilitators.

For field level as well as block level support to ASHA Facilitator, the existing staff of BPHC such as BEE/HE/LHV of the block may be involved in supportive supervision of ASHA Facilitator and on job training of the ASHA Facilitator. There is need for developing effective lingkages between ASHA Facilitator and LHV, ANM, HE and BEE etc. This will make the ASHA program an integral part of the existing system in the block.

As support provided by ASHA Resource Centre (especially DCM and ADM) to the ASHA Facilitator is limited to attending the review meeting of the ASHA Facilitators and orientation, there should be more effective involvement of them in terms of training and developing strategies for enhancing the performance of ASHA Fcailitator. For this purpose they also need effective technical support, and their capacity building in coordination with

existing block level staff of BPHC so as to ensure sustainability of the program in long run. For effective field level intevrention involvement of ANM/LHV/BEE is very critical.

Similarly, State ASHA Resource Centre also needs to be strengthened in terms of analysis and usage of data/reports for desinging effective field level intervention plan (especially for District and Block level staff). The findings/reports may be shared and discussed on table with the State at least on quarterly basis. There has to be effective coordination with existing district level health staffs.

Conclusion

Based on the analysis of the overall findings of the study, it may be recommended to take the following major actions/steps so as to improve the performance of the ASHA Facilitators;

- *Training of ASHA Facilitators on ASHA Module 5, 6 & 7 as well as record keeping.*
- *Orientation of Block Officials (SDM & HO/BPM, ABPM) and Officials of ASHA Resource Centre (DCM, ADCM) on records capturing and maintaining by ASHA Facilitator, its analysis and usage/utility.*
- *Capacity building of State ARC on analysis/usage of data for designing effective intevrntion plan. They inturn will build the capacity of DCM and ADCM on the same.*
- *Separate guard file for each ASHA Facilitator needs to be maintained at BPHC level.*
- *Separate monthly review meeting of ASHA Facilitators at BPHC level on a fix day. This should be attended by ASHA Resource Centre staff especially DCM and ADCM, and SDM &HO/BPM.*
- *ASHA Program should be an integral part of the system, and not a parrellel program especially at block level. This may be done if the staff of BPHC and BPMU are efefctively involved in the program especially in supportive supervision and on-job training of ASHA Facilitator.*
- *Mapping and relocation/transfer of ASHA Facilitators to site/facility which is nearest to their resident village. ASHA Resource Centre (especially DCM/ADCM) may take the initiative.*
- *Revising present honorarium and TA/DA.*
- *Inter District/State exposure visits need to be conducted for cross learning among ASHA Facilitators.*

Annexure:1 **Case Studies of ASHA Facilitators:**

Case Study 1: Nagaon Blues: a case study of ASHA Facilitator of Nagaon

It was always her dream to work for the people in need. With this dream she joined NGO and was working there. But she wanted to work for the people through proper channel with support from all. So, when she saw the advertisement of ASHA Facilitator post under NRHM, she applied for it and she was selected. Before working as ASHA Facilitator she was working with an NGO, Rural Engineering Development Association (REDA) at Bebejia (Hatichung), Nagaon which has a project on HIV/AIDS. Her major contribution as ASHA Facilitator is her partaking in Family Planning and her attachment in VHSC. She visited the house of every eligible couple and motivated them to use Family planning methods both permanent and temporary. She was even able to motivate even the male members for family planning.

Fig1: ASHA Facilitator, Mrs. Smita

Fig2: AF with ASHA in the village

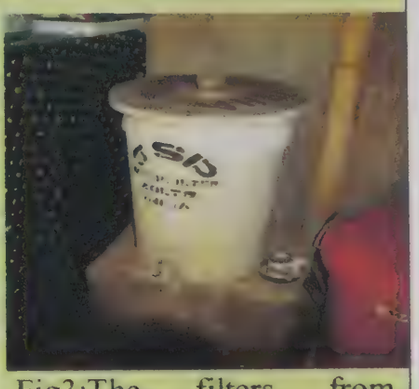

Fig3:The filters from VHSC fund (for BPL family)

She also took active part in VHSC and conducting VHSC meetings. She saw that BPL families of the villages under her area receiving both house and toilet from the government and again they are selected as toilet beneficiaries by VHSC. She was not happy with that and on the other hand she saw that the people from that area are often suffering from diarrhea due to lack of safe drinking water. Many are using river water, tube well water and well water for drinking without filtering it. So, she tried to help out these people. She approach the VHSC member and ask them that if it is possible to arrange for water filter instead of constructing toilet. They agreed with her and asked her to select the beneficiaries. With the help of ASHA of the village she selected the beneficiaries and distributed the water filter. The villagers are happy with this help and the problem of drinking water and diarrhea is under control.

Her over all experience is good. The villages under her was often suffering water born disease but now because of her initiative the problem is almost solve. He: apport with the

community has developed very much after becoming ASHA Facilitator. Though she was already working with the NGO before she became ASHA Facilitator her contact with the community was not like now. In the beginning as ASHA Facilitator the community was not ready to accept her. But after seeing her initiative and hard work they came forward and now she is accepted by the community and well known in the villages under her.

During the initial days she faced a challenge from the community and ASHA. Both community and ASHA didn't accept her. She struggled a lot to be accepted by both. But soon, she got involved herself in the schemes of NRHM. And now every village expects her visit along with ASHA to their house.

She also faces some constraints due to transportation because some village under her are in the interior areas and in those places there is no transport facilities available for which she couldn't give hundred percent involvements in those places. And another constraint for her is to perform her duty in cooperation with the BPMU because whenever she finds that ASHAs & ANM are cheating in the matters of drawing incentives and inform it to BPMU they don't take necessary steps for those ASHA & ANM. Therefore whenever ASHA facilitator showed the lacunas, the BPMU and the ANM/ASHA don't pay much attention to her. The ASHAs under her manipulates the records of JSY and also full immunization with full cooperation from ANM.

She saw that the drug kits given to the ASHA are not used properly therefore, she thinks that some kind of responsibility should be given to AFs too to check whether the drug kit is used properly or not. She wants some power to be given to AFs so that they have some power to solve problems created by ASHA & ANM.

Moreover, she mentioned that they should be given training on various schemes of NRHM, leadership training and the training on role and responsibilities of ASHA facilitator because many ASHA Facilitator lack leadership quality and they are not sure of their own roles and responsibilities.

She is none other than one ASHA Facilitator Smita Saikia who covers 7 ASHAs under Buragohaithan BPHC and covers Bhutaigaon, Mazpathori, and Chakarigaon SC to her acclaim. She is married, 32 years of old and belongs to OBC. She joined as ASHA Facilitator on 15th December 2009. She received trainings for 3days (6th to 8th May, 2010) from the state, Malaria and IPPI Training at the block and 1 day orientation at District after their joining.

While talking to the DCM of nagaon district, it was informed by DCM that while reviewing the ASHA Facilitators every month they are asked to share their experience and success stories, every one speaks that institutional delivery has increases, MMR and IMR has decreased etc. But in the month of January in the Buragohaithan BPHC at the ASHA Facilitator monthly review meeting, Mrs. Smita Saikia shared her success stories about her involvement in the VHSC and Family Planning. DCM also visited the villages and the villagers are really happy by her initiative. She was even threatened for taking such initiative from the fund send for construction of Sanitary Toilet. Even the other ASHA Facilitators

were motivated by her initiative and they too started to take part in the VHSC and they are trying to solve the problems prevailed in the village with the help of VHSC members. Initially the AFs thought that they don't have any role in VHSC and they were never called for the VHSC meeting. But the AF, Smita Saikia has become the role model for the other ASHA Facilitators in the block.

Case Study 2: PRI member turned as ASHA Facilitator: Case study of AF from Kamrup (Rural) District:

A PRI member turned ASHA facilitator in Majirgaon village. Before joining as ASHA facilitator she has been associated with Non Governmental Organization (NGO) and later on selected as a PRI member. Informed about her desire to be an ASHA Facilitator she told that she has decided to join as ASHA Facilitator not only because this job touches the common people but also she wants to be associated with common people for long which ultimately leads to the development of the common people in her locality. The only difference between the job of PRI and ASHA Facilitator is that being a PRI member she never interacted as frequently as ASHA Facilitator with the common people.

Geetarani Goswami hails from Majirgaon village under Azara PHC under Kamrup (Rural) district of Assam. She is 37 years old and still unmarried. On 9th May she joined as an ASHA Facilitator under Azara PHC. She has 10 ASHAs under her from Majirgaon village under Azara PHC area.

The major achievement after her joining as an ASHA Facilitator is that the conflict initially which was exist between PRI and ASHAs regarding VHSC fund and its utilization has come down drastically due to her intervention as PRI, ASHA & VHSC came under one umbrella. She opined that it became possible because of her intervention as an ex-PRI member and her relation to various cultural organizations and NGOs as she is an well known lady in that area admired by all the people in the area.

Case Study 3: Savior of the people; a story of ASHA Facilitator from Dhemaji District:

She is unique and already received the coveted best ASHA Facilitator award given on the Republic Day not only for serving the people of her area tirelessly but also saved one ANM by diving into the water current while coming back after attending a VHND. It was 2 o clock on July 2010 the district is under flood already.

Her name is Ranu Gogoi Tayeng, married and 37 years of age from Dimow village under Silapathar area. The village is dominated by OBCs/ STs, but she belongs to the category of OBC. She has 10 ASHAs to cover. She was a teacher before joining as an ASHA Facilitator on 9th March 2010. Since her joining she has been serving the communities of those areas and helps ASHA to deliver the right and effective messages to the villagers in the time of need. After her joining as an ASHA Facilitator, She thought by herself that the job will not only give her the financial independency and provide a chance to do somethi[illegible] good for the

community but also gives her recognition and respect by the villagers of those villages. Of course as a teacher also she has earned a respect from the locality but there was no financial assistance in that school. Till date she received only Induction training for three days but of course joined various workshops organized by District Health Society, Dhemaji. The greatest achievement of her is to provide 100% immunization and in turn contribute to reduce IMR, MMR & TFR among the community by his die hard attitude to do something really good for the community.

Recalling the dubious flood days in every year she informed that flood is common problem in the district in spite of that also they were organizing VHNDs and conducting regular health *acti*vities which they supposed to do. In the last year flood she and ANM was coming back after conducting a successful VHND but to reach it to their destinations they have to cross a river. While crossing the river the ANM with her fell down in the water from the bamboo bridge over the river. At a loss she also jumped and by cheer good luck she rescued the ANM from the current of the river. The medical fraternity of the block/district appreciated her bravery. Not only that because of her bravery and the health condition of the area she covers she has coveted the best ASHA Facilitator Award in Republic Day 2011.

It is worth mention that the area (10 villages she has been covering) is difficult to access as to go to most of the villages one has to go on foot; there is no motor able road to reach to those areas. When asked about her problems she has faced working as an ASHA Facilitator she informed that she needs more training on health related issues so that she can be able to provide some service to the community while visiting the household with ASHAs which is in turn the demand of the community too. Of course another core area of concern for her is the salary which is low in terms of hard labor she has been doing to deliver various services to the community she is in concern. Furthermore, some vehicle if can be provided to them would be a good incentive for them to work better.

Annex 2:

Interview Schedule for assessment/appraisal of ASHA facilitator

Date of data collection:

me of the state: Assam **Name of the District and Block:**

me of the SC/PHC/BPHC: .....

1. Name of the ASHA Facilitator:.....
2. Age.....
3. Qualification.....
4. Resident Village:.....
5. When did you joined as ASHA Facilitator.....
6. What were you doing before joining as ASHA Facilitator?..
   a)ASHA b) AWW c) NGO worker d) Housewife (not working) e) Teachere) Any other.....
7. Number of ASHA supervise by you .....
8. Number of VHSCs under the area that you cover?.....
9. Number of field visit days conducted in a month (on average)?.....
10. Average number of ASHAs that you interact in each field visit (take average from a month)?..
11. Average number of hours spend with ASHAs during each field visit (take overall avearge)?....
12. The distance of far-most ASHA from your posting sites/facility?.....What is your travel mode
    a. Bus
    b. Rikshaw
    c. Auto
    d. tempo
    e. Walking
    f. Any other.....
13. The distance of nearest ASHAs from your posting site/facility?..... What is your travel mode
    a. Bus
    b. Rikshaw
    c. Auto
    d. tempo
    e. Walking
    f. Any other.....

14. Is there any fix monthly meeting in your area, if yes;

Types of meeting	Place of meeting (SC/PHC/AWW)	Frequency of meeting	Mention day (if it is on a fixed day)	Number of meeting held in last six months	Last meeting held on	Who are the participants other than you	Issue dicuss in general	Your role during the meetings
VHSC								
VHND								
ASHA meeting								
ASHA facilittaor meeting								
Any other meetings								

***Frenquency may be – 1) Yearly 2)halfyearly/bi-annual 3) Monthly 4) Quarterly 5) Weekly etc.

15. Does your VHND happen sparately or is it clubed with immunizationday
    a. Sparately
    b. Clubed with immunization day
16. Is there any amount of fund released from VHSC for VHND meeitng? A) Yes b)No

17. If yes, how much per meeting (in general) – provide amoutn break up – like for overall arrangement and refershment , and incentive for ASHAs?

Description	Amount	Total Amount
Refreshment/Overall Arrangement		
Incentive for ASHA		
Any other		

18. What are the major activities/areas in which you have provided support to ASHAs (Other than the above)?
    a. Newborn and Child Health
    b. Family Planning
    c. Maternal health
    d. Social Mobilization
    e. TB
    f. Malaria
    g. Any other.....

***Pleease mention support provided to ASHAs other than the ones during your field visit (e.g. support provided to ASHAs in the health facilities level)

19. How many rounds of training have you received?

Trainings (mention specific name)	Number of days	Topis covered	When was it held

20. Do you feel that you require more trainings? Yes /No.

21. If yes on which issues ;
    a) Maternal health b)Newborn and child health c) Family Planning
    d)Infectious dieases like TB, malaria e) Social Mobilization f) Any other...

22. In general, what are the major problems faced/facing by ASHAs in your area? (Don't read options)

i. Related to incentive
ii. Related to transport and communication
iii. Related to training/knowledge/skill
iv. Dealing with PRI member
v. Any other.....

23. How did you supported in dealign ASHA's problem? (Don't read options)

i. Motivating her
ii. Meeting PRI person
iii. Providing training to her
iv. Visitign with her to households
v. Any other.....

24. In general. How much money do you earn/receive monthly for your work as ASHA Facilitator?

Honorarium	DA/TA	Total

25. Amount of money that you spend in general in each filed visit or in a month? (in general) Provide break up calculation in terms travel cost/food etc.....

26. What are the major challenges that you faced/are facing as a ASHA facilitator? (Don't read options)

i. Related to honorarium and incentive
ii. Related to transport and communication
iii. Related to knowledge/skill
iv. Providing trainign to ASHA
v. Dealing with PRI member
vi. Any other.....

27. And How do you manage the problem or how do/did you try to manage it? (Don't read options)

i. Just managing with the amoutn receive with anothing left in hand
ii. Reading self and getting knowledge from other

iii. Meeting eith PRI
iv. Any other

28. What are the areas of improvement in healthcare service delivery in your area after your joining? (Don't read options)

i. Increase in institutional delivery
ii. Increase us eof FP methods
iii. Decrease in newborn/child death
iv. Decrease in maternal death
v. Any other

29. And what were your contributions in that (*what are the major activities that you did in last six month)*? (Don't read options)

i. Motivating ASHA
ii. Training to ASHA
iii. Visiting home with ASHAs
iv. Mass awareness
v. Senstization of people
vi. Any other.....

30. Please suggest the areas in which you can contribute for improvement in health care service delivery? *(this questions require an effort on probing)*

***Write observation of the investogator also.

Snapshots:

Discussion with ASHA Facilitator

Outreach Camp; ANM,ASHA, AF

AF conducting ASHA Meeting

ASHA& AF meeting at block

Interview of ASHA Facilitators & orienting them on record keeping

Group Discussion with ASHA Facilitators

Interaction with SDMHO, Ketetong

SDMHO, Hapajan- orienting ASHA Facilitators

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